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		A. BUILDING 00 B. WING	05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CHARM VILLAGE LLC	7212 US HWY 31 S INDIANAPOLIS, IN 46227

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R0000	This visit was for a State Licensure Survey. This visit included the Investigation of Complaint IN00105405 and Complaint IN00105938 Complaint IN00105405 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00105938 - Unsubstantiated - due to lack of evidence Survey Dates: May 7, 8 & 9, 2012 Facility Number: 003283 Provider Number: 003283 AIM Number: NA Survey Team: Barbara Hughes, RN TC Karina Gates, BHS Beth Walsh, RN Census Bed Type: Residential: 65 Total: 65 Census Payor Type: Other: 65 Total: 65	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on May 15, 2012 by Bev Faulkner, RN			

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R0092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to attempt to hold fire drills in conjunction with the local fire department. This had the potential to affect 65 of 65 residents in the facility. Findings include: The fire drill logs were provided by the Maintenance Supervisor at 11:45 a.m., on 5/8/12 and were reviewed at this time. No information could be found to indicate	R0092	**Country Charm Village – Facility #3283 Plan of Correction – June 6, 2012** **Facility Fire Drills with Local Fire Department Finding:** **Based on interview and record review, the facility failed to attempt to hold fire drills in conjunction with the local fire department. This had the potential to affect 65 residents in the facility.** The facility has taken the following steps toward corrective action in this finding, as	06/06/2012

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	any of the drills in 2011 or 2012 were conducted or were attempted to be conducted in conjunction with the local fire department. During interview with the Maintenance Supervisor on 5/8/12 at 11:50 a.m., he indicated he didn't know until February or March, 2012 that the facility was even supposed to be doing fire drills with the local fire department. He indicated no drills were conducted with the fire department in the 8 years he'd been at the facility, nor were they attempted.		outlined below: **Step 1 – Prior to Survey, Facility did Attempt to Conduct Drill with Local Authority** The operative word in this regulation is "attempt." While the survey documents that the facility records and interview indicate that the facility did not attempt to hold a fire drill in conjunction with the local fire authority, further investigation has revealed that the facility did, indeed, attempt to conduct fire drill with the local authority. As the survey indicates, the Maintenance Director was not made aware of this requirement until March, 2012. The Executive Director of facility, Kamala Thomason West, interviewed Maintenance Director, who advised that he made several attempts to the local authority during the months of March and April, 2012. However, the local authority declined to perform requested drills. **Step 2 – Executive Director Schedules to Conduct Fire Drill with Local Authority** On June 6, 2012, the Executive Director, Kamala Thomason West, spoke with the inspector for the local fire authority and arranged for a fire drill in conjunction with the authority. This fire drill is scheduled to occur on June 25, 2012, at 10:30 a.m. The fire inspector and Executive Director have made verbal plans for a second fire drill in conjunction with the authority to occur during	

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			the month of December, 2012. The firm date for December will be scheduled following the drill that is to occur June 25, 2012. Facility is confident this finding has now been satisfied. From this point forward, the facility will annually attempt to conduct two fire drills in conjunction with the local authority. This concludes the Plan of Correction for facility fire drills in conjunction with local fire authority, Tag #0092.	

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to keep the kitchen's ice machine clean and free from stains. This had the potential to affect 65 residents, in a census sample of 65. Findings include: During an observation of the kitchen's ice machine, on 5/7/12 at 12:05 p.m., with the Dietary Manager, a pink and brown stain was noted on the right side, on the inside, of the machine. The stain was finger width and went from the top of the inside of the machine, to the level of the ice. In an interview with Dietary Manager on 5/7/12 at 12:07 p.m., she indicated that the ice machine is on cleaning schedule and she was not sure when it was last cleaned. During a record review of the May Daily Cleaning Schedule, received from the Dietary Manager, on 5/7/12 at 1:30 p.m., it indicated the ice machine is to be	R0154	**Country Charm Village – Facility #3283** **Plan of Correction – June 6, 2012** **Facility Ice Machine** **Finding: Based on observation, interview and record review, the facility failed to keep the kitchen's ice machine clean and free from stains. This had the potential to affect 65 residents, in a census sample of 65.** The facility has taken the following steps toward corrective action in this finding, as outlined below: **Step 1 – Eco Lab Serviced and Cleaned Machine** Eco Lab performed a standard evaluation and preventative cleaning on May	06/06/2012

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	cleaned daily. On the schedule, for the dates 4/30/12-5/6/12, the schedule indicated the machine was cleaned. On 5/7/12 at 1:35 p.m., the Dietary Manager indicated when the ice machine is cleaned daily that includes cleaning and wiping the inside of the ice machine. The Dietary Manager indicated that she did not think the ice machine had been cleaned or wiped down recently, since she had someone clean the ice machine after the stain was noted, and it came off easily.		8, 2012, and a copy of service ticket was given to ISDH prior to survey exit. **Step 2 – Limit Access to Ice Machine to Staff Only** The Executive Director, Kamala Thomason West, conducted interview with Dietary Manager, Donna Estep, regarding the cleaning schedule of kitchen's ice machine. During such interview, Ms. Estep stated she feels very confident that dietary staff members are cleaning the machine on a daily basis, as facility policy dictates. Ms. Estep also advised that residents will sometimes attempt to gain access to the ice machine, and some do, when dietary staff members are serving and are turned away from machine. Residents have been asked to refrain from entering this area and a sign that reads "Employee Use Only" has been attached to the front of the ice machine.	

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			Ice Available to Residents Around the Clock Effective June 4, 2012, the facility has designated the refrigerator located in the activity department as a community refrigerator and freezer in which residents can gain access to ice around the clock. Each day, before leaving the facility, evening shift dietary staff members will replenish ice supply to the community freezer. In addition to this practice, it should be noted that the facility keeps ice water available to residents as follows: •Ice water is served with all meals. •An ice pitcher is located in the foyer area at the front of the facility. •An ice pitcher is located outside the dietary department. **Step 3 – Daily Cleaning Schedule** Facility policy dictates that the ice machine be cleaned on a	

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			daily basis and a cleaning checklist is kept on site for purposes of documenting said cleaning. The machine is to be cleaned on each shift and is generally done following the serving of a meal, when ice levels are lower. This allows staff to clean a larger surface area of machine. **Step 4 – De-Liming of Machine** A new schedule for the de-liming of the ice machine has been formulated and implemented. Per recommendation of Eco Lab, de-liming should occur every two or three months. The most recent de-liming occurred when Eco Lab provided service to machine on May 8, 2012. The next de-liming will occur the first Friday in July 2012, and will continue to occur on the first Friday of every other month. **Step 5 – Evaluation and Preventative Cleaning by Eco Lab Every Six Months**	

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			Eco Lab will be performing their standard evaluation and preventative cleaning every six (6) months. Their last cleaning was performed on May 8, 2012, and their next scheduled date is to occur in November, 2012. This cycle will be documented by dietary department. **Step 6 - In-Service Staff** The Dietary Manager performed an in-service that discussed the ice machine and related protocol for all dietary aides and department heads on June 6, 2012. **Step 7 – Quality Assurance/Ongoing Monitoring of Ice Machine Protocol** The Dietary Manager will be responsible for monitoring the ice machine and related protocol on a daily basis. The Dietary Manager will immediately notify staff, as well as the Executive Director of any deficiencies, should they exist.	

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			The Executive Director will be responsible for monitoring the ice machine and related protocol on a random (defined as weekly) basis. The Executive Director will immediately notify the Dietary Manager of any deficiencies, should they exist. This concludes the Plan of Correction for facility ice machine, Tag #0154.	

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R0185	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing			

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	storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. Based on observation, interview, and record review the facility failed to provide a method to summons a staff person at any time for 17 of 17 residents on the Memory Care Unit. Findings include: An environmental tour of the facility was conducted with the Maintenance Director on 5/8/12 at 11:20 a.m. Upon observation of the rooms located on the Memory Care Unit in which Residents #51, #24, and #37 resided, no call lights could be found. At this time, the Maintenance Supervisor indicated that this particular unit did not have call lights, but wasn't sure exactly why. During interview with the Administrator on 5/8/12 at 2:00 p.m., he indicated if there were a call system on the Memory Care Unit, he believed some of the residents would be able to use it. He indicated residents on Memory Care must verbalize request for assistance from staff or staff must physically be present with a resident in order to assist them.	R0185	**Country Charm Village – Facility #3283 Plan of Correction – June 6, 2012** **Memory Care Unit Call System** **Finding: Based on observation, interview and record review, the facility failed to provide a method to summons a staff person at any time for 17 of 17 residents on the Memory Care Unit.** The facility has taken the following steps toward corrective action in this finding, as outlined below: **Step 1 – Wrist Call Pendants Ordered and Programmed** The Memory Care unit had hardware already in place for a call system for the Memory Care unit. New pendants were ordered and received from Life Line. For safety reasons, management chose wrist pendants rather than the necklace pendants. Pendants were programmed and given to residents. All pendants were tested and are operational. The call system in the Memory Care unit is now operational. **Step 2 – Resident Education and Orientation** This deficiency had the potential to affect all residents of the Memory Care unit. Therefore, all residents were educated and oriented to wrist	06/06/2012

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	On 5/8/12 at 11:30 a.m., the Clinical Director provided a list of 17 residents on the Memory Care Unit.		call pendants. However, given the cognitive level of many of the residents in the Memory Care unit, this will be an ongoing education and orientation process, and residents will frequently be reminded of the purpose of wrist pendants. **Step 3 – In Service with Staff** An in-service for department heads and other staff members was conducted June 6, 2012. The facility Maintenance Director trained staff members on how to operate and trouble shoot the call system. **Responsible Parties and Ongoing Monitoring**All staff members are responsible for ensuring the system is functioning properly. The Maintenance Director has the primary responsibility of ensuring this system is online and operating efficiently. The Executive Director has the ultimate responsibility to ensure this system remains in place, intact and efficient in nature. Both the Maintenance Director and Executive Director will monitor the system daily. This concludes the Plan of Correction for facility's Memory Care unit call system, Tag #0185.	

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R0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, record review and interview, the facility failed to ensure 2 of 14 opened vials of insulin and 1 of 1 opened inhalers were disposed of when expired. This affected Residents # 19 and # 36. Findings include: 1. On 5/7/12 at 1:35 p.m., an observation of Med Cart #2 with LPN#1, there was an Advair 250/50, dated 4/2/12, for Resident #36. LPN#1 was unsure of when the medication was last used. A document titled, Recommended Minimum Medication Storage Parameters (based on Manufacturer Package inserts),	R0306	**Country Charm Village – Facility #3283** **Plan of Correction – June 6, 2012** **Expired Vials of Insulin and Open, Expired Inhalers** **Finding: Based on observation, record review and interview, the facility failed to ensure 2 of 14 opened vials of insulin and 1 of 1 opened inhalers were disposed of when expired. This affected Residents #19 and #36.**	06/06/2012

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	dated 2005, received from the Administrator on 5/8/12 at 11:10 a.m., indicated that Advair is to be discarded one month after removal from the foil pouch or after all blisters have been used, whichever comes first. 2. During an observation of the medication refrigerator, on 5/7/12 at 1:40 p.m., with LPN#1, an insulin vial of Lantus 100 units/ml (milliliter) for Resident #19, was dated 4/5/12 and LPN#1 said she used it the previous night. There was also an insulin vial of Novolog 100 units/ml, for Resident #19, dated 4/5/12. LPN#1 said she used the Novolog at noon that day. In an interview with LPN#1, on 5/7/12 at 1:45 p.m., she indicated that insulins are good for 30 days and that replacements for the Lantus and Novolog have not been ordered to replace the expired insulins. A record review of, Insulin Storage Recommendations, dated 3/27/12 and received 5/8/12 at 11:10 a.m., from the Administrator, indicated that an opened, refrigerated bottle of Lantus is good for 28 days. The Insulin Storage Recommendation also indicated that an open, refrigerated bottle of Novolog is good for 28 days.		The facility has taken the following steps toward corrective action in this finding, as outlined below: **Item 1 Advair 250/50** **Step 1 – Medication Carts Audited by Executive Director** The Executive Director, Kamala Thomason West, audited inhalers on all medication carts. Any expired inhalers were removed and replacements ordered. All inhalers were properly labeled with both "open" and "expiration" dates. Further, as an infection control measure, all inhalers were "double bagged." Executive Director verbally trained those staff members who were on duty at the time of said audits. **Step 2 – Written Memorandum of Policy and Procedure** On June 3, 2012, Executive	

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		A. BUILDING 00 B. WING	05/09/2012

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			Director issued Procedural Memorandum 006, entitled Advair Expiration Dates and Proper Labeling and Packaging. This procedural memorandum was distributed to all nurses and QMA's, who in turn were expected to sign for receipt of memorandum acknowledging they had received, understood and agreed to abide by the contents of memorandum. The memorandum includes verbiage that clearly states "no excuses tolerated," and that any staff member administering an expired inhaler will be held responsible and accountable. **Step 3 – In-Service Conducted by Executive Director** On June 4, 2012, the Executive Director, Kamala Thomason West, conducted in-service on Advair Inhalers. The above referenced memorandum was read and discussed. There was also opportunity for question and answer session. Again, staff	

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			members were advised of zero-tolerance policy and advised that failure to follow policy would result in disciplinary action which could lead up to termination. **Step 4 – In-Service Conducted by PRN Consultant, Al Silver** On June, 4, 2012, PRN Pharmacy Consultant, Al Silver, conducted an in-service on inhalers (which did include Advair). The in-service addressed: types of inhalers, use and proper administration of inhalers, chemical compound and mechanisms of inhalers, proper cleaning and infection control for inhalers, open and expiration dates of inhalers and proper disposition of inhalers. **Step 5 – Quality Assurance** The Director of Nursing, Nancy Golay, will be performing daily checks of the medication carts which will include inhalers. In addition to the DON's daily checks, the	

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			Executive Director will perform random (defined as at least twice weekly) checks of the inhalers that are housed in the medication carts. The nurses and QMA's have the primary responsibility of ensuring that there will be no expired inhalers in the medication carts. The Director of Nursing will do the second check for expired inhalers; and the Executive Director will have the ultimate responsibility of ensuring there are no expired inhalers in the medication carts. **Item 2 <u>Insulins</u>** **Step 1 – Refrigerator and Medication Carts Audited by Executive Director** The Executive Director, Kamala Thomason West, audited all medication carts and refrigerator. Any expired insulin vials were removed and replacements ordered.	

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			All insulin vials (as well as their packaging) were properly labeled with both "open" and "expiration" dates. Executive Director verbally trained those staff members who were on duty at the time of said audits. **Step 2 – Written Memorandum of Policy and Procedure** On June 2, 2012, Executive Director issued Procedural Memorandum 001, entitled Insulin Expiration Dates and General Insulin Guidelines. Attached to this memorandum was PRN Pharmacy's Policy Number 5.09, entitled Insulin Injection. This procedural memorandum was distributed to all nurses and QMA's, who in turn were expected to sign for receipt of memorandum acknowledging they had received, understood and agreed to abide by the contents of memorandum. The memorandum includes verbiage that clearly states, "Injection of expired insulin is	

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			a serious error that will result in disciplinary action that could lead to suspension and/or termination." Please note, facility understands that QMA's can not administer insulin. However, QMA's were included in this memorandum because they can assist nurses by checking expiration dates and re-ordering insulin when necessary. **Step 3 – In-Service Conducted by Executive Director** On June 4, 2012, the Executive Director, Kamala Thomason West, conducted in-service on insulin and expiration dates. The above referenced memorandum was read and discussed. There was also opportunity for question and answer session. Again, staff members were advised of zero-tolerance policy and advised that failure to follow policy would result in disciplinary action which could lead up to termination.	

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			Step 4 – In-Service Conducted by PRN Consultant, Al Silver On June, 4, 2012, PRN Pharmacy Consultant, Al Silver, conducted an in-service on insulin. The in-service addressed: types of insulin, proper administration of insulin, chemical compound and mechanisms of insulin, open and expiration dates of various types of insulin and proper disposition of insulin. **Step 5 – Quality Assurance and Ongoing Monitoring** The Director of Nursing, Nancy Golay, will be performing daily checks of the refrigerator and medication carts which will include insulin. In addition to the DON's daily checks, the Executive Director will perform random (defined as at least twice weekly) checks of insulin that is housed in the refrigerator and medication carts. The nurses and QMA's have	

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			the primary responsibility of ensuring that there will be no expired insulin. The Director of Nursing will do the second check for expired insulin; and the Executive Director will have the ultimate responsibility of ensuring there is no expired insulin in the refrigerator or medication carts. The facility is confident it has corrected this immediate finding. However, these are items that requires daily monitoring in facilities. Therefore, this Plan of Correction will be ongoing in nature. This concludes the Plan of Correction for expired vials of insulin and open, expired inhalers, Tag #0306.	

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R0406	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review and interview, the facility failed to follow accepted standards and practices to ensure the disinfection of glucometers between resident use. This had the potential to affect 13 of 13 residents requiring glucose monitoring, in a census of 65. (Resident #46, 9, 19, 64, 23, 27, 15, 52, 38, 25, 11, 21, and 33) Findings include: During an Accucheck (fingerstick glucose testing) observation of Resident #11 on 5/8/12 at 11:30, LPN#2 cleaned off the glucometer with an alcohol swab after the Accucheck measurement was taken. Then LPN#2 took an Accucheck measurement of Resident #46 at 11:35 a.m., and wiped off the glucometer with an alcohol swab. In an interview with LPN#2, on 5/8/12 at 11:37 a.m., she indicated they only used alcohol wipes to clean the glucometers and they do not use disinfecting/bleach wipes to clean the glucometer between	R0406	**Country Charm Village – Facility #3283** **Plan of Correction – June 7, 2012** **Disinfection of Glucometers between Resident Use** **Finding: Based on observation, record review and interview, the facility failed to follow accepted standards and practices to ensure the disinfection of glucometers between resident use. This had the potential to affect 13 of 13 residents requiring glucose monitoring, in a census of 65.** The facility has taken the following steps toward corrective action in this finding, as outlined below: - **Step 1 – Facility**	06/07/2012

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	residents or any other time. A request was made of the Clinical Director for a policy for cleaning the facility glucometer. She provided a document titled, "Most Often Asked Questions regarding Tag 441," no date indicated, on 5/8/12 at 12:45 p.m. The document indicated that glucometers should be disinfected with an EPA-registered disinfectant effective against Hep (Hepatitis) B, Hep C, and HIV, or a 1:10 bleach solution. The document also indicated that alcohol can not be used alone to disinfect glucometers. Also indicated was the failure to clean and disinfect after each use can lead to cross contamination between patients as the caregiver moves from patient to patient. On 5/8/12 at 1:52 p.m., in an interview with the Clinical Director, she indicated the facility only uses alcohol to clean and disinfect glucometers. The Clinical Director indicated there were 13 residents in the facility who required testing with the glucometer. Residents #46, 9, 19, 64, 23, 27, 15, 52, 38, 25, 11, 21, and 33. On 5/8/12 at 2:30 p.m., the Clinical Director provided an another document titled, Standard/Universal Precautions and Infection Control, dated 5/24/10, it		**Purchased Gluco-Chlor Disinfecting Towelettes** On May 9, 2012, facility purchased Gluco-Chlor towelettes from Gulf South Medical Supply. Upon shipment of such towelettes, staff implemented their use for the purposes of disinfecting glucometers. **Step 2 – Written Memorandum of Policy and Procedure** On June 4, 2012, Executive Director issued Procedural Memorandum 009, entitled Proper Disinfection of Glucometers between Resident Use. This procedural memorandum was distributed to all nurses and QMA's, who in turn were expected to sign for receipt of memorandum acknowledging they had received, understood and agreed to abide by the contents of memorandum. The memorandum includes verbiage that clearly states "no excuses tolerated," and that any staff member who does not follow proper	

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	indicated that equipment should be cleaned and decontaminated after contact with blood or other potentially infectious material....an EPA approved disinfectant solution should be used as a disinfectant solution. The clinical record for Resident #11 was reviewed on 5/9/12 at 12:00 p.m. The diagnoses for Resident #11 included, but were not limited to: diabetes, hypertension, hypothyroidism. The other 12 residents requiring testing with the glucometer were not known to have Hepatitis (Hep) B, Hep C, or HIV.		infection control procedures will be subject to disciplinary action which could lead to termination. **Step 3 – In-Service Conducted by Executive Director** On June 7, 2012, the Executive Director, Kamala Thomason West, conducted in-service on Proper Disinfection of Glucometers. The above referenced memorandum was read and discussed. There was also opportunity for question and answer session. Again, staff members were advised of zero-tolerance policy. **Step 4 – Quality Assurance** The Director of Nursing, Nancy Golay, will be continually monitoring to ensure that staff members are exercising proper infection control measures when using glucometers. The Executive Director will perform random (defined as at least twice weekly) observations of AccuChecks to ensure proper	

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			infection control procedures are being followed. The nurses and QMA's have the primary responsibility of ensuring that glucometers are properly disinfected between residents. The Director of Nursing is responsible for follow up and daily monitoring, while the Executive Director will have the ultimate responsibility of ensuring proper infection control measures are exercised. **Step 5 – Ongoing Monitoring and Supervision** The term of this Plan of Correction is ongoing. While this finding has been corrected and we are now in compliance, it is an item that requires continual monitoring within facilities. Therefore, the above quality assurance program will continually remain in place. This concludes the Plan of Correction for disinfection of	

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			glucometers, Tag #0406.	